Southend-on-Sea Borough Council

Agenda Item No.

Report of Deputy Chief Executive (People)
to
People Scrutiny Committee

On 9th October 2018

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Council Motion re Mid and South Essex Sustainability and Transformation Partnership

A Part 1 (Public Agenda Item)

1 Purpose of Report

1.1 To provide a report for the People Scrutiny Committee (Scrutiny) to consider regarding the Mid and South Essex Sustainability & Transformation Partnership (STP) Council motion, which was previously considered at both the Council meeting on 19 July 2018 and Cabinet on 18 September 2018.

2 Recommendations

2.1 That Scrutiny notes the Resolution made by the Council at its meeting on 19 July 2018 where the Council unanimously agreed that Scrutiny should "give due consideration to referral to the Secretary of State (SoS), taking these objections and other relevant factors into account" (see section 4).

2.2 That Scrutiny consider the options outlined in section 6 of this report.

2.3 That Scrutiny agree the preferred option to refer the STP to the SoS as outlined in Option C, section 6.

3 Background

3.1 During the process of public consultation re the proposals for the STP Southend Borough Council (SBC) formally responded. In summary, the report acknowledged the need for transformation within health services across the STP footprint and offered support for the STP proposals once the proposals had been sufficiently developed to address areas of particular concern for SBC.

3.2 The areas of concern expressed were; (1) stroke services; (2) investment in Localities; (3) transfers and transport; (4) consolidated discharge and repatriation; (5) capital investment; and (6) workforce.

3.3 On 6 July 2018 the CCG Joint Committee made decisions following recommendations made by the STP programme. These recommendations were made following consideration of the public consultation, clinical senate reports and developed proposals for each of the recommendations. The decisions taken by the CCG Joint Committee are outlined in a formal letter from the CCG Joint Committee Chair to the Chair of the Joint Health Overview and Scrutiny Committee (JHOSC), see **Appendix 1**.

The role of the Joint Health and Overview Scrutiny Committee (JHOSC)

3.4 The JHOSC was formed between SBC, Essex County Council and Thurrock Council and held its' first formal meeting on 20 February 2018. Further formal meetings have been held on 13 March, 6 June and 30 August. A further JHOSC meeting will be held on 30 October 2018.

3.5 On 22 March 2018 the Chair and Vice Chairs of JHOSC wrote to the STP stating their formal position regarding the proposals for consultation. In summary the JHOSC noted a number of concerns regarding the STP and offered support for the STP.

3.6 Scrutiny will be aware that the power of referral to the SoS was not delegated by the three participating Local Authorities to the JHOSC.

4 Council Motion

4.1 Following the CCG Joint Committee decision outlined in **Appendix 1**, a motion was considered at the SBC Full Council meeting of 19 July for consideration. The details of the motion are in **Appendix 2**.

4.2 In summary, the motion reiterated the concerns outlined in the Council's response to the STP proposals and further expressed concern at the public consultation process and how it had reached only a small fraction of the population within the STP footprint.

4.3 The motion was unanimously supported by all Members present and was carried (Minute 182, Council 19 July 2018 refers).

4.4 On 30 August 2018 JHOSC considered the decisions made by the CCG Joint Committee. The JHOSC further considered SBC's motion and noted the following;

4.4.1 That the JHOSC take full account of SBC's continued objections to the STP; and

4.4.2 That SBC's Full Council had requested that SBC's Scrutiny give due consideration to a referral to the SoS, taking into account SBC's continued objections to the STP, the progress made by the STP regarding SBC's objections and any other relevant factors.

5 Making a referral

Process

5.1 In guidance published by the Department of Health (DoH) the process to make a referral to SoS is clearly outlined, full guidance is detailed in **Appendix 3**.

5.2 In summary; if a Local Authority is minded to refer a proposed health service change to the SoS an information pack containing the following information would need to be compiled. The expectation is that any referring Local

Authority will be expected to provide very clear evidence-based reasons for the referral;

- An explanation of the proposal to which the report relates.
- An explanation of the reasons for making the referral.
- Evidence in support of these reasons.
- Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.
- Where the proposal is referred because there was no consultation for reasons relating to safety or welfare of patients or staff, reasons why the health scrutiny body is not satisfied that the reasons given for lack of consultation are adequate.
- Where the health scrutiny body believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.
- An explanation of any steps that the health scrutiny body has taken to try to reach agreement with the relevant NHS body or health service provider.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has been made.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has not been made, or where no comments have been provided on the proposal.

5.3 Upon receipt of referral the SoS has the option of seeking the advice from the Independent Reconfiguration Panel (IRP) who are an independent expert on NHS service change. The IRP is an advisory, non-departmental public body, sponsored by the Department of Health and Social Care. A document describing who the IRP are and how the IRP advises the SoS is detailed in **Appendix 4**.

5.4 There is no time limit in which the SoS would seek the advice of the IRP. The majority of referrals made by Local Authorities to SoS are subsequently referred to the IRP.

5.5 Once the advice of the IRP has been sought the IRP will attempt to provide written advice to SoS within 20 working days. The majority of cases are responded to within this time limit. However, the IRP makes it clear that they accept information from a wide range of stakeholders and any information submitted for the IRP to consider by the referring authority (or other interested stakeholders) will be duly considered. This may have an impact on the 20 working day timescale, subject to volume of information.

5.6 The IRP will publish its' advice to the SoS once it has been submitted to the SoS.

5.7 On receipt of advice from the IRP the SoS will consider the advice and provide a written response to the referring authority either upholding the

referral or otherwise. There is no time limit within which the SoS must provide a written response.

5.8 A recent example of advice provided by the IRP is detailed in **Appendix 5**.

Criteria for making a referral

5.9 Within the Guidance there are four broad circumstances for a referral to be made. A referring authority may report to the SoS, in writing, if;

- It is not satisfied with the adequacy of content of the consultation;
- It is not satisfied that sufficient time has been allowed for consultation (NB the referral power in the context of inadequate consultation only relates to the consultation with the local authority, and not consultation with other stakeholders);
- It considers that the proposal would not be in the interests of the health service in its area; or
- It has not been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate

Adequacy of content of the consultation

5.10 This criteria for referral will only apply if a referring authority agrees that it is not satisfied with the adequacy of consultation. To support this debate it is appropriate for both the process and outcome of the public consultation to be considered.

5.11 An independent report looking at responses to the CCG Joint Committee public consultation (Your Care in the Best Place) was published on 22 May 2018, full report is detailed in **Appendix 6, click here for link**. The report, produced by specialist consultation analysts, The Campaign Company, provides a breakdown of both the process and responses to proposals aimed at strengthening and improving health and care services in the community and in the three hospitals serving mid and south Essex.

5.12 The analysis indicates there is broad agreement with the overall principles described in the consultation, these were;

- The majority of hospital care will remain local and each hospital will continue to have a 24-hour A&E department that receives ambulances
- Certain, more specialist, services which need a hospital stay should be concentrated in one place, where this would improve your care and chances of making a good recovery
- Access to specialist emergency services, such as stroke care, should be via your local (or nearest) A&E, where you would be treated and, if needed, transferred to a specialist team, which may be in a different hospital
- Planned operations should, where possible, be separated from patients who are coming into hospital in an emergency
- Some hospital services should be provided closer to you, at home or in a local health centre. The specific proposal within the consultation concentrated on moving services currently provided from the Orsett

Hospital site into centres closer to where people live, enabling the closure of Orsett Hospital

5.13 The analysis identifies some local differences, particularly that there was less general agreement with the proposals from those living in the Southend CCG area.

5.14 The analysis report has also shown key themes of concern particularly in the areas of;

- Transport and accessibility of services
- Shortages in workforce to deliver a sustainable service
- Financial constraint

5.15 The 16-week consultation saw 16 large scale public meetings with circa 700 people attending in total, and 40 deliberative workshops and specific events for people who were most likely to be affected by the proposals.

5.16 750 people took part in an independently commissioned telephone survey conducted with a demographically-balanced section of the population across Mid and South Essex.

5.17 In total it is estimated that circa 3,500 (total population of circa 1.2M) people took the opportunity to participate. This equates to circa 0.3% of the mid and south Essex population having engaged in the public consultation.

5.18 The independent report outlines the process conducted by the CCG Joint Committee and recognises that the overall response cannot be seen as representative of the population but is representative of interested parties who were made aware of the consultation and were motivated to respond. The report further recognises that a telephone survey was undertaken with a randomly selected and representative cross section of residents to ensure that the consultation process accurately captured the views of the wider population of mid and south Essex. The report notes that 7% of respondents had heard of the consultation and 29% had read the consultation document. The report comments that this is in line with other known NHS consultations where telephone surveys had taken place.

5.19 Whilst circa 0.3% is a small proportion of the population it would be considered a difficult case to argue that both the process conducted to consult and the small proportion of those consulted would support a referral to the SoS on the basis of inadequate consultation.

Sufficient time allowed for consultation with Local Authority

5.20 Where an NHS body consults with more than one local authority on a proposal for substantial development of a health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. For the purposes of the Mid and South Essex STP the JHOSC (refer to paragraph 3.4) was created early 2018.

5.21 Since its' first formal meeting in February 2018 the JHOSC has engaged with the STP on a number of occasions to scrutinise the proposals for health services in mid and south Essex.

5.22 At the request of the JHOSC the time allowed by the CCG Joint Committee to consult with the JHOSC was extended. Originally, the consultation was due to

close on 9 March 2018. At the JHOSC meeting on 13 March the STP advised that the CCG Joint Committee had extended the close date for consultation to 23 March 2018. This, then, allowed for the JHOSC to formulate a response.

5.23 The regulations did not require for the CCG Joint Committee to formally consult with the local scrutiny committees. Notwithstanding this the STP has engaged with SBC via a number of different means since early 2016; including engagement with People Scrutiny Committee, Southend Health and Wellbeing Board, STP Health and Wellbeing Boards Chairs' meeting and a facilitated visit to Southend Hospital to visit stroke services. This engagement has taken place on numerous occasions and focused on STP related issues.

5.24 In consideration of the circumstances it would be considered a difficult case to argue that insufficient time was allowed to consult.

Proposals not in the interest of the health service

5.25 As stated in paragraph 3.6 the power of referral was not delegated by the three participating local authorities to the JHOSC.

5.26 The IRP have therefore advised that any referral to the SoS could be considered in the context of whether the STP proposals are not in the interests of the health service in the Southend area rather than the health service in the mid and south Essex area.

5.27 It could, therefore, be possible to construct an argument that supports a referral to the SoS based on the STP not being in the interests of local health. This is explored in greater detail in Section 6.

No consultation

5.28 The regulations set out criteria on which consultation with health scrutiny is not required (**in full pp 24-25 Appendix 3**). These are;

- A risk to safety or welfare of patients;
- Where the proposals are to establish or dissolve the constitution of a CCG; or
- Where proposals are part of a trusts special administrators report.

5.29 It was considered by the CCG Joint Committee that the above criteria did not apply in the deliberations about whether or not to consult.

5.30 The CCG Joint Committee decided to formally consult with the public. The 'no consultation' criteria to make a referral to SoS is therefore, considered to not be relevant in the deliberations of Southend Scrutiny.

6 Options for Scrutiny to consider

Option A – SBC do not make a referral to the SoS, accept the decisions made by the CCG Joint Committee and continue to work in partnership with the STP to ensure the concerns highlighted by SBC re the STP are addressed

Assessment

6.1 The CCG Joint Committee have acknowledged that the STP plans are not finalised and require further development prior to implementation. The CCG Joint Committee have particularly acknowledged that the plans for workforce,

capital investment, implementation and transport (treat & transfer, family, friend and carer) plans will evolve throughout the planning for implementation.

6.2 On a number of issues the CCG Joint Committee have been able to circulate more detailed proposals to both the JHOSC and local scrutiny committees. On other issues detailed proposals have not been made available to either JHOSC or local scrutiny committees, these issues include workforce, capital investment and implementation.

6.3 As referenced in paragraphs 3.1 and 3.2 SBC responded to the public consultation and expressed a number of concerns. The concerns were, and remain; (1) stroke services; (2) investment in Localities; (3) transfers and transport; (4) consolidated discharge and repatriation; (5) capital investment; and (6) workforce.

6.4 Since the CCG Joint Committee made its' decision and through continued pressure from both the JHOSC and SBC the plans for transfers and transport and primary care have been developed further and been made available for public scrutiny.

Benefit

6.5 Capital investment for the STP proposals will be made available.

6.6 The relationship built between SBC and the STP will be further strengthened through working in partnership.

Risk

6.7 Concerns raised by SBC (paragraph 6.3) would only be addressed in a timescale and manner that aligns with the STP programme.

6.8 There is no guarantee that the concerns would be resolved to the satisfaction of SBC and its residents and if they were not satisfactorily resolved it would be deemed too late in the process to change course.

Option B – refer the STP in its' entirety to the SoS on the basis of 'inadequate consultation' and 'not in the interests of local health services'

Assessment

6.9 In its' response to the CCG Joint Committee, SBC, at the end of public consultation, highlighted a number of areas that are positive for the local resident of Southend. SBC fully recognised the need for change to the provision of acute services in mid and south Essex and recognised that the current model was unsustainable for reasons of recruitment, retention, financial sustainability. SBC further recognised that, due to changing demand and innovations in technology there was a need to change and improve services. In its' report SBC welcomed the additional capital investment that would support the STP proposals.

6.10 To refer the STP to the SoS in its' entirety (on the basis of 'not in the interests of local health services') would require SBC to disagree with all of the decisions made by the CCG Joint Committee. Eg, quicker access to the range of treatments offered at the existing Essex Cardiothoracic Centre in Basildon, the enhancement of operations at Southend A&E department 24hrs a day and the development of trained specialist teams.

6.11 To refer the STP to the SoS in its' entirety (on the basis of 'inadequate consultation') would require SBC to challenge the independent report

produced following the public consultation. Whilst the public consultation reached a small proportion of the mid and south Essex population it is credible to suggest that the STP made every effort to consult with local residents and hard to reach groups. As noted in the independent report the volume of response is a difficult issue to influence and is not considered to be grounds for an 'inadequate consultation' referral.

Benefit

6.12 A benefit of adopting this approach would be that the referral would represent the views of a small proportion of Southend residents.

Risk

6.13 The STP have already indicated that the hospitals are unable to progress the capital bid process to draw down the £118m (c£40m for Southend Hospital). The process to draw down capital funding within the health service is long and complex (approximately 12-18 months taking into account strategic outline case, outline business case and full business case, and various approval routes (NHS Improvement, DH, Treasury)). Any delay in commencing this process will have a significant impact on accessing capital for schemes such as the additional hospital wards at Southend.

6.14 Development of detailed implementation, finance and workforce plans (per pathway) will be delayed, with impacts on:

- Patient benefits that would occur as a result of service changes
- Staff - continued uncertainty, and resultant impact on recruitment and retention.
- Services where there are issues with sustainability (eg. because of rota gaps or increased demand) remain fragile
- Financial sustainability of the system

6.15 The cost of referral (both financial and human resource), for both SBC and NHS England.

6.16 Potential delay in implementation of the locality approach (if identified investment requirements are reliant on bringing activity (and funding) from the acute sector).

Option C – refer decision #12 re Stroke Services on the basis that the hyperacute clinical treatment model is acceptable (subject to appropriate resourcing) but that the development of a specialist team in Basildon Hospital to provide intensive nursing support and rehab is not.

Assessment

6.17 As outlined in paragraphs 3.1 and 3.2, SBCs formal response to the public consultation was that whilst the STP proposals were broadly supported there were significant areas of concern that SBC still had which were not in the interests of local health services, that impacted on the sustainability of health services in Southend and delivered reduced outcomes for the residents of Southend. The issues were, and remain; (1) stroke services; (2) investment in

Localities; (3) transfers and transport; (4) consolidated discharge and repatriation; (5) capital investment; and (6) workforce.

6.18 Since the CCG Joint Committee decision on 6 July 2018 a number of steps have been taken by the STP to address SBC's concerns. Steps which have included developing the proposals for treat and transfer, friends, family and carer transport, clinical pathways, primary care and the out of hospital community model.

6.19 It is important to acknowledge that there are some decisions that have been made by the CCG Joint Committee that will improve health outcomes for Southend patients. For example quicker access to the range of cardiology services offered at the existing Essex Cardiothoracic Centre in Basildon and the earmarking of £118M in capital funding from central funds, of which circa £40M is allocated to Southend Hospital.

6.20 The five principles consulted on included the principle that certain, more specialist, services which require an inpatient stay should be concentrated in one place, where this would improve care and chances of a good recovery.

6.21 This model / principle is supported by the East of England Clinical Senate who confirmed that the proposals for service change would deliver improvements to patient care. The proposals / service model developments were developed by leading front-line consultants and have been recognised as improving the quality, outcome and safety of care.

6.22 Whilst it is recognised that specialist services, which require an inpatient stay, would benefit from being concentrated in one place there is very little evidence to support the location of a number of the CCG Joint Committee decisions in Basildon. For example decision #12 which refers to the care for patients showing symptoms of a stroke continuing to be via the nearest A&E, where patients will be assessed, stabilised and treated, if clinically appropriate. Patients who have had a stroke will then transfer to Basildon Hospital for a short period of intensive nursing and therapy support. The decision further recognises that where a patient is confirmed as suffering from a bleed on the brain, they will continue to be transferred to a designated centre, as now. The CCG Joint Committee strongly supported the ambition to develop a mechanical thrombectomy service but makes no recognition that a thrombectomy service (on a best endeavour approach) is currently provided from Southend Hospital.

6.23 During the course of public consultation locally elected Members from a number of different political parties from SBC visited the stroke unit at Southend Hospital to discuss the STP proposals.

6.24 Members left the visit very clear that a model had been developed between the lead consultants for each acute site that places the patient at the centre. The immediate and timely hyperacute clinical intervention is paramount to the delivery of a successful model. The fast reaction of the model to identify patients with strokes (using hyperacute imaging), the ability to quickly identify the cause of the stroke and hyperacute clinical intervention delivered thereafter are all primary considerations of the model.

6.25 The resourcing of the hyperacute clinical intervention model was also a topic of conversation and Dr Guyler (Lead Consultant for Stroke Medicine) outlined the required resource at each site for the model to function effectively. Clare

Panniker (Chief Executive Mid, Southend and Basildon Hospital Group) confirmed to the Members and assured the meeting that the STP proposals committed to resourcing each site appropriately as defined by the model Dr Guyler outlined.

6.26 The decision for the reconfiguration of stroke services and development of a hyperacute clinical intervention model is supported with clinical evidence. However the rationale to incorporate a specialist stroke unit at Basildon Hospital, where patients will receive a short period of intensive nursing and therapy is less clear and poorly documented in the CCG Joint Committee Decision Making Business Case.

6.27 The Stroke Association supports the proposals for stroke services as agreed by the CCG Joint Committee, report is detailed in **Appendix 7**. In summary, the report specifically supports the development of the model outlined in the CCG Decision Making Business Case. The Stroke Association further support the development of a specialised stroke service which will provide intensive nursing and therapy. Whilst the report supports the development of the specialist service at Basildon Hospital the Stroke Association were not asked to appraise any alternatives. For example, the Stroke Association were not requested to comment on whether or not the specialist stroke service should be based at Southend.

Not in the interests of local health services

6.28 It is arguable to suggest that the decision to locate a specialist stroke service at Basildon Hospital that will provide intensive nursing and therapy is not in the interests of local Southend health services.

Evidence to support location of Specialist Stroke service at Basildon Hospital

6.29 Throughout the numerous engagement events held between Southend and the STP requests were made for the rationale and evidence base that supported the location of a specialist stroke service, providing intensive nursing and therapy support, at Basildon Hospital. The evidence base that supports the CCG Joint Committee decision has never been made available to either Officers or Members at SBC.

6.30 The limited evidence that has been published in the CCG Joint Committee Decision Making Business Case indicates that there are clinical connections between a cardio thoracic centre and stroke services. The clinical evidence to support this has not been made available.

6.31 The CCG Joint Committee Decision Making Business Case also makes reference to the fact that workforce issues will be resolved as a result of locating specialist stroke services at Basildon Hospital. Both the JHOSC and Southend Scrutiny have requested the evidence to support this rationale. The evidence has not been made available.

Strokes in Southend

6.32 Southend has the highest number of strokes (within the STP footprint) per 1,000 population over the age of 65. The data (17/18) shows that the Southend rate is 7.5 which is significantly higher than Basildon and Mid Essex. Not only does Southend have the highest rate of strokes within the STP, the rate has been steadily increasing (15/16, 16/17 & 17/18) as

compared to Basildon and Mid Essex which have been steadily decreasing or remaining constant.

6.33 Stroke Admissions for Southend Hospital have been steadily increasing year on year. The rate of admissions to Southend Hospital that have been classed as a 'stroke admission' has grown from 694 (14/15) to 734 (16/17). This equates to SUHFT admitting circa 14 stroke cases per week as compared to circa 11 per week each for both Broomfield and Basildon Hospitals, taken from 16/17 data.

Existing infrastructure

6.34 Southend Hospital is audited by the Sentinel Stroke National Audit Programme (SSNAP). The most recent audit demonstrates that all three acute hospitals in the mid and south Essex STP have similar audit reports. The evidence and rationale to support the locating of a Specialist Stroke service at Basildon Hospital is not available and raises questions as to why the locating of Specialist Stroke service at Southend Hospital has been over looked.

6.35 Southend has an international airport and a Medical Technical campus which would allow Southend Hospital to attract research funding. There are concerns over whether or not this issue has been considered in the CCG Joint Committee decision making process. In addition, Southend Hospital have consistently demonstrated leadership with regards to the development of stroke services, for example; a mobile stroke unit and a best endeavour thrombectomy service.

Workforce

6.36 Both the CCG Joint Committee and SBC have recognised the significant challenge associated with workforce which will need to be addressed to enable the successful implementation of the STP.

6.37 Despite numerous requests from both JHOSC and SBC the detailed workforce information which is required to provide assurance has not provided by the CCG Joint Committee. As noted in paragraph 6.25, the Chief Executive of Mid, Southend and Basildon Hospital Group confirmed to SBC's locally elected Members that resourcing for the clinical hyperacute intervention model (both at local sites and specialist stroke services) would be made available. To date, neither the JHOSC nor SBC have received any information to provide assurance that this commitment is robust.

6.38 By creating a specialist stroke service evidence suggests that lives will be saved and disabilities will be reduced. Access to and availability of a specialist stroke workforce continues to be a problem for delivering high quality evidence based stroke care. The British Association of Stroke Physicians has stated 'Clinical developments in UK stroke services have overtaken the specialist resource needed to support them'. The creation of a specialist stroke service (irrespective of location) will allow for the existing specialist workforce in mid and south Essex STP to be used more effectively to provide evidence based interventions that save lives and reduce disabilities.

6.39 Additionally, there is no published evidence that addresses the workforce challenges that would be created as a result of the additional transport requirement (patient, friends, family, carer etc) following the implementation of specialist stroke services at Basildon Hospital.

Benefit

6.40 Southend residents will receive better outcomes as a result of developing a hyper acute clinical treatment model based at Southend and also a specialist rehab centre located on an evidence base that is transparent.

Risk

6.41 The hospitals cannot progress the capital bid process to draw down the investment aligned to stroke services from the £118m investment (c£40m for Southend Hospital). The development of a specialist stroke service for the STP is towards the end of the STP implementation programme. Other decisions made by the CCG Joint Committee can be implemented (including the drawdown of capital funding) whilst a referral of Stroke services is being considered by the SoS.

6.42 Development of detailed implementation, finance and workforce plans (per pathway) associated with the development of stroke services will be delayed.

6.43 The cost of referral (both financial and human resource), for both SBC and NHS England

6.44 Potential delay in implementation of the locality approach (if identified investment requirements are reliant on bringing activity (and funding) from the acute sector).

7 Preferred Option

7.1 In consultation with colleagues from Southend Public Health the options outlined above have been considered which support Scrutiny to respond to the Full Council Motion (detailed in **Appendix 2**). For the reason that it is not in the interests of local health it is recommended that Scrutiny adopt Option C, as outlined and detailed in paragraphs 6.17 - 6.446.44.

8 Other options

8.1 There are no other options for consideration.

9 Corporate Implications

9.1 Contribution to the Council's Vision and Critical Priorities – Becoming an excellent and high performing organisation.

9.2 Financial Implications – The financial risks to Southend Council, should the STP proposals be delivered, are yet to be identified.

9.3 Legal Implications – Where an NHS body consults with more than one local authority on a proposal for substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that joint committee may - make comments on the proposal to the NHS body; require the provision of information about the proposal; require an officer of the NHS body to attend before it to answer questions in connection with the STP proposals

9.4 People Implications – The expectation is that the STP proposals will address the workforce (recruitment and retention) issues highlighted in the case for

change. There is a significant risk that this is not the case which could lead to greater challenges for workforce and finance.

9.5 Property Implications – as described in the report.

9.6 Consultation – as described in the report.

9.7 Equalities Assessment (EA) – an EA was published by the STP during spring 2018. The Directors for Public Health, across the STP worked in partnership with the STP to develop the EA.

9.8 Risk Assessment – The risks associated with the options are outlined in this report. There is a risk to the local health and social care system of not doing anything.

10 Background Papers

11 Appendices

11.1 Appendix 1 – CCG Joint Committee decisions taken re STP proposals 6 July 2018

11.2 Appendix 2 – Minute 182, Council 19 July 2018

11.3 Appendix 3 – DoH guidance for Local Scrutiny

11.4 Appendix 4 – Who are the IRP

11.5 Appendix 5 – IRP advice examples

11.6 Appendix 6 – Independent STP consultation report (click here) (report otherwise available in Member room).

11.7 Appendix 7 – Stroke Association letter